

Exploring Stigmatization and Stigma Management in Mental Health Court: Assessing Modified Labeling Theory in a New Context

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Abstract

Drawing on Link and colleagues' modified labeling theory, this paper examines whether the stigma management strategies defendants anticipate using after mental health court exit are associated with their reported experiences during court. Using survey data from 34 mental health court graduates, we find that respondents generally perceive the mental health court as procedurally just, did not experience stigmatizing shame, and anticipate using the inclusionary coping strategy of education over the exclusionary strategies of secrecy and withdrawal. Moreover, findings reveal that the anticipated use of stigma management strategies is associated with mental health court experiences in that procedural justice is associated with inclusionary coping strategies, while stigmatizing shame is associated with exclusionary coping strategies. We conclude by encouraging researchers to further explore the role of stigmatization and shame in specialty court contexts and to continue investigating these defendant perceptions of these courts' process.

Keywords: Mental Health Court, Stigmatizing Shame, Procedural Justice, Modified Labeling Theory, Specialty Courts

INTRODUCTION

Sociology has a long history of studying stigma and its consequences. Much of the theorizing on individual responses to stigma uses a labeling framework. Within the study of deviance, scholars argue that attaching a negative label results in a status change and a transformation of identity that causes further deviance (Becker 1963; Lemert 1951). In the sociology of mental illness, the causal role of stigmatizing labels received attention in the classic debates of Scheff and Gove. Scheff (1966) argued that the process of being labeled “mentally ill” causes individuals to conform to the expectations of that label and produces a stable pattern of mentally ill behaviors, while Gove (1975) argued that deviant labels are a consequence of mental illness – rather than a cause. These debates within labeling theory encouraged the development of Link and colleagues’ modified labeling theory (Link et al. 1987; Link et al. 1989; Link and Phelan 2001).

Stepping away from the causal role of stigma, the theory posits that individuals are aware of their label and use stigma management strategies to cope with the perceived threat of rejection or social exclusion that might come from the label. Strategies include using education, withdrawal, and secrecy. Although the use of these strategies is significant in understanding human behavior, the strategy one selects also has widespread implications for future social outcomes. For example, endorsing secrecy or withdrawal might isolate one from social relationships or lower self-esteem thereby limiting opportunities (Link et al. 1989).

Mental health courts provide a compelling context in which to examine stigma and the use of stigma management strategies. These courts are one of the many new programs aimed at reducing criminal offending among persons with mental illness by

diverting them from the criminal justice system into the community mental health system (Broner et al. 2004; Steadman et al. 1995). Since the late, 1990s, the number of mental health courts in the United States has grown tremendously, with over 300 courts in the United States in operation today (Goodale et al. 2013). Although some scholars suggest that mental health court experiences may intensify stigma (Behnken et al. 2009; Tyuse and Linhorst 2005; Wolff 2002), to date no studies have examined the perceptions of stigma among mental health court defendants. In an effort to spark interest in this area of inquiry, we present results from an exploratory survey of mental health court graduates in which we examine feelings of procedural justice, stigmatizing shame, and stigma management strategies. In doing so, this research attempts to centralize the perspective of the defendant in understanding and identifying effective justice interventions.

Mental Health Courts

Given the large numbers of persons with a mental illness in the criminal justice system, and the fact that many of these individuals repeatedly cycle through the system, jurisdictions have implemented various diversionary programs. The mental health court is an example of a post-booking diversion program and attempts to reduce criminal offending by diverting criminal offenders with mentally illness into needed treatment and services (Goodale et al. 2013). While mental health courts vary in their processes and organization some general similarities between the courts have been outlined (Almquist and Dodd 2009; Thompson et al. 2003). For example, mental health courts rely on a non-adversarial team approach in which criminal justice and mental health practitioners come together to develop individualized plans for defendants with mental illness. Additionally,

mental health court participation is voluntary, so the terms of participation are presented to the defendant, who decides whether or not to enroll in the court, often in consultation with counsel or other supporters. If the defendant decides to enroll in mental health court, the team members assist the individual in making and attending appointments with community-based treatments and services, and evaluates compliance with mandates for behavioral change during regularly scheduled court status hearings. If one opts out of the mental health court, which they can do at any time, the case is sent back to traditional criminal court for adjudication; otherwise, after remaining compliant for an allotted period of time, the defendant's charges are dismissed or the sentence is reduced.

Empirical research on mental health courts suggests that individuals who participate in the mental health court process—and especially those who complete the process—have fewer arrests while under court supervision and once they exit the court (Christy et al. 2005; Cosden et al. 2003; Dirks-Linhorst and Linhorst 2012; Frailing 2010; Herinckx et al. 2005; Hiday et al. 2013; Hiday and Ray 2010; McNiel and Binder 2007; Moore and Hiday 2006; Steadman et al. 2011; Trupin and Richards 2003). These evaluations have been conducted in different mental health court settings, with unique teams, treatments, services, and providers, yet all find reductions in recidivism (see Sarteschi et al. 2011, for meta-analysis of mental health court evaluations). Such consistencies have led some researchers to suggest that there may be something specific to the mental health court experience—apart from the mental health treatment—that reduces criminal offending (Hiday et al. 2013).

The most common theoretical mechanism that has been used to describe this process is procedural justice, which postulates that making fair decisions and having

respectful relationships with defendants can lead to increased compliance with court mandates and the law (Tyler 2006). Some researchers suggest that in mental health court judges are in an ideal position to demonstrate procedural justice. She or he is able to treat the defendants with respect, explain decisions, and give them voice and validation (McIvor 2009; Poythress et al. 2002; Wales et al. 2010). As such, studies have found that mental health court defendants report higher levels of perceived procedural justice with the judge than defendants in traditional court (Poythress et al. 2002). More recent research has shown that perceptions of procedural justice in mental health court are associated with more positive attitudes about recovery and compliance (Kopelovich et al. 2013) and successful completion of the mental health court process (Redlich and Woojae 2013).

Another mechanism that has been postulated to explain mental health court's crime reduction is Braithwaite's (1989) concept of reintegrative shaming. Shame is generally understood as a negative emotion that come from experiences of failure relative to one's own standards or the standards of others (Lewis 1992); however, Braithwaite suggests that shame ultimately results in feelings of stigmatization or reintegration. With stigmatizing shame, the individual feels humiliated, negatively labeled, and cast out of the community of law abiding citizens. Yet shame can lead to feelings of reintegration if the negative labeling is focused on the behavior rather than the individual, the individual feels respected during the shaming process, and if the shaming process concludes with words or gestures of forgiveness. In both types, the actual shaming process can be cruel, but when shame is stigmatizing, it also provokes feelings of anger, resentment, and can encourage participation in negative activities. Because of these negative emotions,

Braithwaite suggests that when an individual feels stigmatizing shame, they are more likely to commit further criminal behavior while reintegrative shame reduces the likelihood.

To examine stigmatizing shame and reintegrative shame, Ray, Dollar, and Thames (2011) used observational instruments from the Australian Reintegrative Shame Experiments (RISE) to compare shaming types across a mental health court and traditional criminal court. They found that mental health court proceedings contained more elements of reintegrative shaming, while traditional court proceedings contained more elements of stigmatizing shame. However, this study captured observer perceptions of the mental health court process, not the defendants' own insights.

Modified Labeling Theory

Link and colleagues' (1989) modified labeling theory assumes that during socialization, an individual forms beliefs about how mental illness is treated. For example, an individual may believe that persons with mental illness are discriminated against or treated as outcasts. These beliefs become particularly relevant if and when the individual is diagnosed or treated for symptoms related to mental illness because those beliefs are applied to oneself, thus, discrimination and negative reactions are anticipated. When this happens, Link et al. (1989) posit that individuals employ stigma management strategies to cope with the anticipated stigma. Link et al. (1989) propose three such strategies: education, withdrawal, and secrecy. *Education* involves disclosing information and contextualizing one's stigma with the expectation that it will enlighten others and deflect negative reactions. *Withdrawal* limits contact to those who are already aware or

accepting of one's stigma. *Secrecy* encourages one to withhold information about their stigma and often involves concealing information from others—such as potential employers, friends, or family members—to avoid anticipated discrimination.

While adopting one or more of these strategies can assist an individual in coping with a negative label, they can also result in unconstructive social outcomes. Relying on secrecy as a stigma management strategy may encourage feelings of dissimilarity or shame. Withdrawal can result in social network constriction, which limits opportunities that could aid in successful social integration. Education more directly confronts negative social perceptions, and does not limit social opportunities and integration, but may inadvertently expose one to discrimination.

Early empirical research on modified labeling theory found that expectations of rejection were associated with income loss, unemployment, and demoralization (Link 1987). Moreover, those who feared rejection most were likely to endorse withdrawal as a stigma management strategy and as a result had limited social networks (Link et al. 1989; see also Perlick et al. 2007). Studies have also linked anticipated discrimination from mental illness to a number of different outcomes such as adherence to mental health treatment (Sirey et al. 2001), low self-esteem (Link et al. 2001; Wright et al. 2000), isolation (Wright et al. 2007), depressive symptoms (Link et al. 1989; Perlick et al. 2007), and a reduced quality of life (Rosenfield 1997).

While the modified labeling perspective was originally designed to examine the effect of stigma from mental illness, the theory's framework is constructed in such a way that it can be applied to any set of negatively stereotyped beliefs that might cause individuals to adopt stigma management strategies. As such, the theory has been used to

explain behaviors among smokers (Houle and Siegel 2009), parents of children with disabilities (Green 2003), persons living with HIV/AIDS (Fife and Wright 2000), and body image (Fee and Nusbaumer 2012; Mustillo et al. 2012). Recently, the theory has received increased attention in criminology. Scholars suggest that mental patients and inmates are both marked with a highly discredited and often permanent label that has strong negative stereotypes attached to them (Winnick and Bodkin 2008). Research has examined perceptions of stigma and the stigma management strategies used among arrestees and former inmates (LeBel 2012; Murphy et al. 2011; Tangney et al. 2011; Tewksbury 2012; Winnick and Bodkin 2008). Moreover, drawing on the re-entry literature (Travis 2005), some of these studies have re-conceptualized the stigma management strategies of Link and colleagues (1989) as promoting either *exclusionary* or *inclusionary* behavior. Winnick and Bodkin (2008) argue that underlying each strategy are incongruous forces that foster either social inclusion or exclusion. Education promotes *inclusion* through the development of supportive social relations, which necessarily decreases one's inclination to withdraw or keep his or her stigmatizing label secret. However, secrecy and withdrawal encourage *exclusion* through self-initiated social closure which limits opportunities for creating and fostering open relationships.

To explore modified labeling theory in the context of a mental health court, we examine whether the experiences one has during court are associated with the types of stigma management strategies they plan to utilize once they are no longer under supervision. Mental health court experiences are captured by measuring reported perceptions of procedural justice and stigmatizing shame.

DATA AND METHODS

Setting and Participants

The mental health court from which our sample is drawn has been in operation since 2000 and is located in a midsized town in southeastern United States. The court relies on deferred prosecution, so defendants are not required to plead guilty before court participation and are not required to meet particular “phases” prior to completion. Defendants must attend monthly court status hearings, and their progress is monitored by the court team for at least six months. To successfully complete (i.e., graduate from) the program, the defendant must remain compliant with the court’s orders for a specified amount of time.

Part of the court’s stipulation in granting permission to interview graduates was that the interviews be completed in a short amount of time. The presiding judge of the court informed the authors that “graduation is done at the beginning of the court session so that they [the graduates] can leave early, while the other defendants have to stay, so the interviews need to be short enough so that when the court session ends the graduate is able to leave before everyone else.” To accommodate this requirement, the survey was developed with the expectation that it could be completed in approximately 10 minutes.

The authors completed face-to-face interviews using a close-ended survey instrument. Interviews were conducted with 34 mental health court graduates over a nine-month period (June 2011 to March 2012). This sample represents all but three graduating defendants for a 12-month period. One defendant declined participation, and two others agreed to participate and signed consent forms but left before the interviews began.

Interviews were completed immediately following the graduation ceremony.¹ The interviews took place in small conference rooms located inside the courthouse. Only the interviewer and graduate-defendant were present. As part of the informed consent, the participants were reminded that their answers were confidential and that none of the responses would be shared with mental health court staff. They were also told that their responses would have no bearing on disposition of their criminal charges or affect any treatment they were receiving.

Measures

Procedural Justice. We use five items to measure perceptions of procedural justice. Following extant research, our items focus on procedural justice interactions with the judge (Poythress et al. 2002; Wales et al. 2010) and tap into feelings of voice and validation (“Did you have enough of an opportunity to tell the judge about your personal and legal situation?”), respectful treatment (“Did the judge treat you respectfully?” and “Did the judge seem genuinely interested in you as a person?”), fairness (“Did the judge treat you fairly?”), and satisfaction with the outcome (“Are you satisfied with how the judge treated you and dealt with your case?”). Responses were presented using a 7-category option and ranged from *not at all* to *definitely* with higher scores suggesting

¹ The graduation ceremony involves the judge calling the defendant’s name at the beginning of court, leading the courtroom in applause, and verbally congratulating and describing the progress the defendant has made. The judge also presents the defendant with a graduation certificate and publicly dismisses criminal charges.

greater perceptions of procedural justice. The five procedural justice items revealed a Cronbach's Alpha of 0.83 and a mean score of 5.88 ($SD = 1.35$).

Stigmatizing shame. We examine the extent to which respondents report feelings of stigmatizing shame from their mental health court experiences using modified items from the Act Justice Survey (Harris and Burton 1998). These items are designed to capture an offender's feelings of stigmatizing shame that result from treatment in the criminal justice system and were also selected to test the validity of earlier observational findings that suggests mental health courts are unlikely to practice stigmatizing shaming (see Ray et al. 2011). The survey items tap into feelings of being labeled ("The people at mental health court treated me like I was going to commit another crime," "During mental health court, people made negative judgments about the kind of person I am"), being treated as though one had a deviant master status ("During mental health court, people treated me like I am criminal," "During mental health court, people treated me like I am a bad person"), and being shamed ("They made me feel ashamed of myself," "They criticized me for what I had done"). Prior to reading the survey items aloud, the interviewers prompted respondents to think about their experiences in mental health court and how they were treated by the staff, so these answers reflect a comprehensive experience in the mental health court rather than specific interactions with any specific team member. Using a 5-category response with options ranging from *strongly agree* to *strongly disagree*, the respondents reported the extent to which they agreed with each statement. The six stigma items have a Cronbach's alpha of 0.88 and a mean score of 1.90 ($SD = 0.68$).

Stigma Management Strategies. We measure stigma management strategies using modified survey items from Winnick and Bodkin's (2008) stigma management scales, which were based off Link and colleagues (1989) devaluation-discrimination scale. Because the mental health court team allowed only a brief period of time to survey each graduate, we were unable to include the full battery of devaluation-discrimination and stigma management items. Rather, we selected three questions from Winnick and Bodkin's (2008) scale, one for each of the three coping strategies (i.e., education, withdrawal, and secrecy), and modified the referent to reflect mental health court rather than conviction: "I feel I should tell other people what mental health court is like" (education), "If someone thinks less of me because I was in mental health court, I would avoid them" (withdrawal), and "I feel like I need to hide the fact that I was in mental health court from other people" (secrecy). Respondents were asked to report the extent to which they anticipated employing each using 5-category response options, ranging from *strongly agree* to *strongly disagree*.

Sample characteristics. The mental health court participant's date-of-birth, race-ethnicity, and sex were obtained from public court dockets. Additionally, we asked survey questions regarding the respondent's current employment and romantic relationship status to look for differences in procedural justice, stigmatizing shame, and stigma management strategies.

FINDINGS

Sample Characteristics

Table 1 depicts the sample characteristics. The average age of respondents is 35 years. There are nearly an equal numbers of males (52.9%) and females (47.1%), and the majority of the respondents identify as White (82.4%). Over half of the sample report being currently employed at least part-time (55.9%) and nearly half report being in a romantic relationship at the time of the survey (44.1%).

[Table 1 about here]

Perceptions of Procedural Justice and Stigmatizing Shame

We capture two types of mental health court experiences: procedural justice and stigmatizing shame. As illustrated in Table 2, the defendants report relatively high levels of procedural justice. Consistent with surveys in other mental health court settings (Poythress et al. 2002; Wales et al. 2010), respondents generally report positive feelings about their experiences with the mental health court judge. Also consistent with findings from other mental health court settings, we found that the respondents had the lowest values for the item measuring the opportunity to voice ($M = 4.47$), and the highest values in feeling respect ($M = 6.41$) (see Poythress et al. 2002: 527).

[Table 2 about here]

The survey items on stigmatizing shame also suggest generally positive experiences in that respondents largely perceived the mental health court as non-stigmatizing (i.e., lower values indicate less stigmatizing shame). The values in Table 3

show that respondents overwhelmingly disagreed that the mental health court processes were stigmatizing. Item 3, which asks “During mental health court, people treated me like I am a criminal”, shows the greatest variation with a mean of 2.35 (SD = 1.23).

[Table 3 about here]

When examining procedural justice and stigmatizing shame by sample characteristics we found some differences (results not shown). Procedural justice is moderately and positively associated with age ($R = 0.53, p < .001$), and persons involved in a romantic relationship report higher procedural justice scores than those who are not (6.46 and 5.42, $t = 2.39, p < .05$); however, there are no differences in procedural justice by sex, race, or employment status. In terms of stigmatizing shame, the only significant difference is by employment: those employed were less likely to perceive stigmatizing shame than those who were not (1.63 and 2.24, respectively; $t = 2.86, p < .01$). Finally, while procedural justice and stigmatizing shame are negatively associated, bivariate analysis did not reveal a significant relationship between the measures.

Stigma Management Strategies

We examine three stigma management strategies: education, withdrawal, and secrecy. As shown in Table 4, over three-quarters (76.5%) of the respondents anticipate endorsing education as a stigma management strategy. Nearly one-third (29.4%) of respondents report their intention to endorse withdrawal, and only 8.8% anticipate using secrecy as a stigma management strategy. Respondents had the ability to support more

than one stigma management strategy and were not required to rank, prioritize, or select only one strategy; however, there are distinct patterns in the responses. For example, most of those who endorsed education did not endorse using any other coping mechanism (76.9% of the respondents who selected the education strategy) and of those who did, all state that they anticipate using withdrawal (23.1%) but not secrecy. Moreover, all persons who endorse secrecy also endorse withdrawal.

[Table 4 about here]

Table 5 illustrates procedural justice and stigmatizing shame scores by each of the three stigma management strategies: education, withdrawal, and secrecy. We conduct an Analysis of Variance (ANOVA) to examine differences in these scores across the three strategies and find that both perceptions of procedural justice and stigmatizing shame differed significantly across the anticipated stigma management strategies ($F(2, 36) = 4.15, p < .05$ and $F(2, 36) = 11.67, p < .001$, respectively). We also conducted a Tukey post-hoc comparison to determine in which groupings these differences occur (i.e., between education-secrecy, education-withdrawal, or secrecy-withdrawal). We find that procedural justice scores were higher among those who endorse education significantly higher ($M = 6.40, 95\% \text{ CI } [6.08, 6.72]$) than those who endorse withdrawal ($M = 5.32, 95\% \text{ CI } [4.05, 6.59], p < .01$). Additionally, persons reporting higher perceptions of stigmatizing shame were less likely to endorse education ($M = 1.72, 95\% \text{ CI } [1.48, 1.96]$) as opposed to secrecy ($M = 3.11, 95\% \text{ CI } [1.78, 4.44], p < .01$) or withdrawal group ($M = 2.48, 95\% \text{ CI } [2.08, 2.89], p < .05$). These results collectively indicate, then, that higher

than average procedural justice scores are associated with education, while higher than average stigmatizing shame scores are associated with both secrecy and withdrawal.

[Table 5 about here]

Finally, to explore the effect of procedural justice and stigmatizing shame on stigma management strategies net of sample characteristics, we create a continuous outcome variable that represents a continuum of the three stigma management strategies. As noted above, underlying each coping strategy are attitudes that foster either *inclusion* (education) or *exclusion* (secrecy and withdrawal), with inclusion fostering social relations and exclusion limiting one's opportunities and hindering social networks (e.g., Winnick and Bodkin 2008). To create a continuous measure capturing inclusive relative to exclusive coping, we reverse code the education item so that higher scores represent stronger agreement (i.e., more inclusive coping) and combined them with the secrecy and withdrawal items, which remain coded so that lower values indicate higher inclusive coping. Thus, defendants who strongly agreed with using education and strongly disagreed with secrecy and withdrawal had the highest scores and were most likely to anticipate inclusive coping post mental health court inclusion score.

This continuous stigma management outcome measure ranges from 7 to 15 with a mean value of 11.5 ($SD = 2.50$) and a modal value of 12 (29.4%). To assess whether associations between procedural justice and stigmatizing shame with stigma management hold while controlling for sample characteristics, we conduct OLS regression analysis. Table 6 shows the results of this model. Net of controls, both procedural justice and

stigmatizing shame are significantly associated with the stigma management strategy one expects to employ. As expected, procedural justice is positively related to employing inclusive coping while stigmatizing shame is negatively related. Thus, these regression analyses provide further support for the finding that procedural justice is associated with inclusionary coping (education) and stigmatizing shame with exclusionary coping (withdrawal and secrecy).

[Table 6 about here]

SUMMARY AND CONCLUSIONS

Mental health court is a unique and important context in which to examine stigmatization and stigma management strategies. Defendants in these programs have been formally labeled as both a criminal and as a person with a mental illness; thus, they are likely to have anticipated or experienced stigmatization associated with both labels. Some have argued that separating defendants with mental illness into a separate court might foster a harmful link between criminal offending and mental disorder, which could increase feelings of stigmatization (Behnken et al. 2009; Tyuse and Linhorst 2005; Wolff 2002).

The present study is exploratory in that that is the first to examine perceived stigma among defendants in a mental health court, and while the sample consists of a small number of surveys with graduates, there are still several noteworthy findings. First, most defendants report high levels of procedural justice and low levels of stigmatizing shame during the court proceedings. These perceptions of procedural justice findings are

consistent with those from other mental health court sites (Poythress et al. 2002; Wales et al. 2010), and reports of low stigmatizing shame supports observational research that suggests that mental health courts are less likely to practice stigmatizing shame than traditional criminal courts (Ray et al. 2011). We explore differences in these perceptions by sample characteristics and find some differences. Specifically, older respondents and those in a romantic relationship report the mental health court as more procedurally just, while employed respondents report feeling less stigmatized by their court experiences. Interestingly, we find no statistically significant association between our measures of procedural justice and stigmatizing shame; however, given the small sample size, we are hesitant to dismiss an empirical relationship. Given that procedural justice is positively related to inclusive coping and stigmatizing shame with exclusive coping, it is likely that with a larger sample or a study that assesses experiences over time in court, we might find a relationship between these concepts. Future studies on defendant's perceptions might consider more closely assessing the potential relationship between these two experiences to investigate their link to program compliance and outcomes.

In addition, while it was not the majority, some defendants did report experiencing stigmatizing shame from the mental health court process. This finding is especially important since the measure of stigmatizing shame we use in the present analysis is more potent than measures that inquire about one's negative feelings of failure that come with shame. Stigmatizing shame, as reported herein, captures perceptions of humiliation and rejection that are the direct result of participation in the mental health court process. Also, the fact that some defendants report stigmatization is especially important given that the present analysis uses data collected only from mental health

court graduates. Graduates have effectively remained compliant with the court's mandates for a significant length of time and many have been involved with the mental health court for several months. To this end, the graduates have received a full "dose" of the mental health court treatment protocol, which includes individualized treatment, services, supervision, and encouragement (Moore and Hiday 2006). Moreover, upon successfully completing the program they took part in a graduation ceremony wherein they were publicly congratulated, encouraged, and had their criminal charges dismissed. Yet, some defendants still reported stigmatizing shame from the court process. Over half of all persons who enroll in mental health court do not successfully complete it (see Burns et al. 2013); therefore, even if unintentional, it is important to consider the degree of stigmatization that may be operating in the court. Although our findings do not assess perceptions of procedural justice or stigmatizing shame among non-graduates, future research should examine these mechanisms among those who are not accepted into or who do not complete the mental health court process.

Finally, most respondents reported that they expect to manage stigma by using inclusive coping, yet this varied significantly by perceptions of the mental health court experience. We look at differences in procedural justice and stigmatizing shame across the stigma management strategies of education, withdrawal, and secrecy, and also create a combined measure of these stigma management strategies, which captures variability in respondent's likelihood to use inclusive rather than exclusive coping. We find that even after controlling for sample characteristics, perceptions of procedural justice are positively associated with inclusive coping, while stigmatizing shame is negatively related. That is, those defendants with high procedural justice perceptions indicated they

were more likely to endorse education suggesting they would contextualize their court experiences and use inclusive coping strategies. However, while relatively few in number, those who experience stigmatizing shame in the mental health court are more likely to endorse withdrawal and secrecy implying that they may keep their participation a secret or ostracize themselves from situations to avoid discussing it. These findings suggest that feelings of stigmatization may encourage the use of particular management strategies, which have widespread implications for one's future opportunities and relationships. Thus, the experience one has in mental health court has an impact on how they might behave post exit, which in turn might affect one's quality of life, compliance with treatment, or future criminal behavior. This finding suggests diversionary processes should consider the need to provide pro-social interventions for stigmatized groups in order to create an experience that allows members to disclose and discuss illness and deviance in ways that minimize subjective and objective stigmatization.

Although our study provides a benefit to the literature on stigma management and perceptions of stigmatization among mental health court participants, it is not without its limitations. Our analyses are limited by having a relatively small sample of participants from a single mental health court; as such all results should be interpreted cautiously as they may not be generalizable to other courts. Additionally, the survey items we used focus on the respondents' perceptions of stigmatizing shame specifically related to mental health court experiences. Due to limitations on the length of the survey we were unable to include the full devaluation-discrimination scale or ask about other potential sources of stigma—such as having a mental illness or a criminal record—which might play a role in perceptions of the mental health court. Moreover, we were not able to

capture real instances of discrimination or stigma and so our data focus on the anticipated use of stigma management strategies rather than actual use of those strategies. This limitation is present in other studies of modified labeling theory and hinders our understanding of exactly how management strategies influence social outcomes.

We were also unable to capture the perceptions of defendants who did not complete the mental health court process. Although we originally intended to interview all defendants who had enrolled in mental health court, including those who did not complete the mental health court process, defendants were often terminated due to their lack of participation and attendance at court-mandated appointments. Because the defendants did not consistently appear at court where our interviews took place, we were unable to survey them. Finally, we surveyed respondents immediately following their graduation ceremony while they were still in the courthouse. Although we understand that this may inflate reports of satisfaction about mental health court experiences, we chose to obtain information at that time in order to obtain the data efficiently and acquire the highest response rate possible. The effects of survey timing on exaggerated reports of satisfaction, however, is an important matter for empirical analysis, and future research may benefit from examining participant perceptions of their court experiences in the days, months, and years that follow.

Despite these limitations, the present research is important in raising awareness about the stigmatization among mental health court defendants, including their anticipation of managing the dual label of “criminal” and “mentally ill.” To this end, we encourage other scholars to explore the presence and consequences of stigmatization among other specialty court populations. Because specialty courts share the goal of

providing a more therapeutic setting than the traditional criminal court (see Tiger 2011) and given the proliferation of these courts, it is crucial to not only determine whether they reduce recidivism, but also how defendants perceive the process.

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Table 1: Sample Characteristics

Variable (<i>N</i> = 34)	Mean	SD
Age	35	10.3
Sex	N	%
Male	18	52.9
Female	16	47.1
Race		
White	28	82.4
Nonwhite	8	23.5
Employed		
Yes	19	55.9
No	15	44.1
In a Relationship		
Yes	15	44.1
No	19	55.9

Table 2: Perceived Procedural Justice from Mental Health Court Experience

Procedural Justice Items	Mean	SD
1. At mental health court, did you have enough opportunity to tell the judge what you think he needed to hear about your personal and legal situation?	4.47	2.71
2. Did the judge seem genuinely interested in you as a person?	5.94	1.86
3. Did the judge treat you respectfully?	6.41	1.16
4. Did the judge treat you fairly?	6.29	1.38
5. Are you satisfied with how the judge treated you and dealt with your case?	6.29	1.19
<i>Procedural Justice Mean Index</i>	5.88	1.35

7-point scale ranging from 1 = *not at all* to 7 = *definitely*; Cronbach's alpha = 0.83

Table 3: Perceived Stigmatization Shame from Mental Health Court Experience

Stigmatizing Shame Items	Mean	SD
1. The people at mental health court treated me like I was going to commit another crime.	1.97	0.8
2. During mental health court, people made negative judgments about the kind of person I am.	1.65	0.6
3. During mental health court, people treated me like I am a criminal.	2.35	1.23
4. During mental health court, people treated me like I am a bad person.	1.82	0.87
5. They made me feel ashamed of myself.	1.82	0.87
6. They criticized me for what I had done.	1.79	0.64
<i>Stigmatizing Shame Mean Index</i>	1.90	0.68

5-point scale ranging from 1 = *strongly agree* to 5 = *strongly disagree*; Cronbach's alpha = 0.88

Table 4: Anticipated Stigma Management Strategies Post Mental Health Court

	Strongly Agree and Agree	
	N	%
1. I feel I should tell other people what mental health court is like. (education)	26	76.5
2. If someone thinks less of me because I was in mental health court, I would avoid them. (withdrawal)	11	29.4
3. I feel like I need to hide the fact that I was in mental health court from other people. (secrecy)	3	8.8

5-point scale ranging from 1 = *strongly agree* to 5 = *strongly disagree*

Table 5: Analysis of Variance (ANOVA) on Mental Health Court Experiences by Stigma Management Strategies

<i>Mental Health Court Experiences</i>	Education ^a (n = 26)		Secrecy (n = 3)		Withdrawal (n = 10)		ANOVA	
	Mean	SD	Mean	SD	Mean	SD	<i>F</i> (2, 36)	
Procedural Justice	6.40	0.80	5.32	1.78	5.27	0.46	4.15	***
Stigmatizing Shame	1.72	0.60	2.48	0.56	3.11	0.54	11.67	**

p < .01, * p < .001

^a Groups are not mutually exclusive

Table 6: OLS Regression Predicting Inclusive Coping

Variables	Estimate		SE
Intercept	10.46	***	2.02
Age	0.03		0.03
Female (1 = yes)	0.51		0.46
White (1 = yes)	-0.84		0.57
Employed (1 = yes)	0.50		0.58
In Relationship (1 = yes)	0.53		0.48
Procedural Justice	0.66	**	0.22
Stigmatizing Shame	-2.15	***	0.42
Adjusted R^2	0.749	***	

** $p < .01$, *** $p < .001$

Table entries are unstandardized coefficients.